

State File No. ....

FILED MAY 29 1943

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 1209

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
53 Claverach Dr. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 53 Claverach Dr.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

In this community \_\_\_\_\_  
years, months or days

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1943 hour 5 minute 45 p. M.  
21. I hereby certify that I attended the deceased from 1939  
\_\_\_\_\_, 19\_\_\_\_, to 5-21, 1943  
that I last saw him alive on 5-21, 1943  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Marie Potter

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife Dr. Charles Potter 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 16 1867  
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Austria  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Urban Heinsch

13. Birthplace Austria  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Austria  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Julius C Potter

(b) Address 53 Claverach Dr.

17. (a) Burial (b) Date thereof 5-25-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Bur. Pl.

18. (a) Signature of funeral director Witt Bro. L. No.  
(b) Address 2929 S. Jefferson Av.

19. (a) MAY 24 1943 (b) C. J. McManis, M.D.  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Arteriosclerotic heart disease - Coronary thrombosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) none  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature J. Stumm (M. D. or other) M.D.  
Address 1634 N. Grand Date signed 6/25/43

Duration for years

PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

P. O. Address *2929 S. Jefferson*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**